Stony Brook Medicine

ADULT SPEECH PATHOLOGY
SWALLOWING HISTORY FORM

Name: _____
Date of Birth: _____

Reason for this evaluation: _____
Previous Swallow Evaluation: □ No □ Yes □ Stony Brook □ Other: _____

Past Medical History – please provide date of onset for any YES responses

Anxiety/Depression	□YES	□NO	Laryngitis	□YES	□NO
Autism	□YES	□NO	Learning Disability	□YES	□NO
ADD/ADHD	□YES	□NO	Lung Cancer	□YES	□NO
Asthma/COPD	□YES	□NO	Mental Retardation	□YES	□NO
Allergies	□YES	□NO	Oral/Tonsil Cancer	□YES	□NO
Brain Cancer	□YES	□NO	Pneumonia	□YES	□NO
Bronchitis	□YES	□NO	Radiation Therapy	□YES	□NO
Cardiac Disease	□YES	□NO	Shortness of breath	□YES	□NO
Chemotherapy	□YES	□NO	Seizures	□YES	□NO
Cerebral Palsy	□YES	□NO	Sleep Apnea	□YES	□NO
Cleft Palate	□YES	□NO	Speech/Lang Impairment	□YES	□NO
Dementia	□YES	□NO	Stroke (CVA/TIA)	□YES	□NO
Diabetes	□YES	□NO	Swallowing Problems	□YES	□NO
Gastric Reflux	□YES	□NO	Surgery	□YES	□NO
Head/Neck Cancer	□YES	□NO	□ Cancer □ Head & Neck □ Other: _____		
Head/Neurological Injury	□YES	□NO	Thyroid Cancer	□YES	□NO
Hearing Loss	□YES	□NO	Tracheostomy tube	□YES	□NO
High Blood Pressure	□YES	□NO	Thyroid Disease	□YES	□NO
Kidney Disorder	□YES	□NO	Visual Impairment	□YES	□NO
Leukemia	□YES	□NO	Voice Impairment	□YES	□NO
			Ventilator Dependency	□YES	□NO

How do you take Medication? □ With water □ In puree □ Other: _____
List medications or attach list:

Please check any of the following specialists seen in past: □ Physical or Occupational Therapist
□ Ear Nose and Throat Specialist □ Eye Specialist □ Neurologist □ Psychiatrist/Psychologist □ Pulmonologist
□ Cardiologist □ Neuropsychologist □ Speech/Language Pathologist □ Audiologist (Hearing Test)

Family and Social History: Please check all that apply
□ Working □ Student □ Unemployed □ Retired □ Live alone □ Tobacco user d/c date: _____
□ Alcohol use ___/day □ Recreational drug use

Swallowing problem: □ Gradual Onset □ Sudden Onset □ Past few weeks □ Past few months □ 6-12 months
□ Over ____ years □ Improved over time □ Gotten worse over time □ Stayed the same over time

Current diet/nutrition/hydration: Check all that apply □ Feeding tube □ Regular □ Cut up/soft foods
□ Finely chopped □ Puree □ Thin liquids □ Slightly thick liquids □ Nectar thick liquids □ Honey thick liquids
□ Good appetite □ Fair appetite □ Poor appetite □ Recent weight loss - __# of lbs. over ___ weeks/mos.
□ Food allergies: _____ □ Other: _____
_____# meals/feedings per day Length of meal time: _____ minutes □ Assistance with meals

 Reviewed by SBUH SLP _____
Initials

Name: _____
Date of Birth: _____

Describe any management strategies you are using to swallow: _____
_____

Do you wear dentures? □ No □Yes Circle: Upper / Lower / Partial
Current physical status: □ Walk independently □ Walker □ Cane □ Wheelchair
Please describe your voice: □Normal □ Hoarse □Breathy □Weak □ No voice

Do you experience any of the following? (Check all that apply)

□ Poor morning voice quality
□ Frequent throat clearing
□ Increased phlegm in the throat
□ Tastes repeating after meals
□ Increased throat/mouth dryness
□ Frequent burping
□ Feeling of throat tightness
□ Throat soreness or burning sensation not related to illness
□ Coughing episodes not related to illness/swallowing
□ Heartburn (If checked, how many times per week? ____)
□ Feeling of a lump in the throat when swallowing
□ Bad taste in the mouth (sour, acidic, metallic)
□ Unpredictable/variable voice quality during the day
□ Increased coughing when lying down

Additional Information:
_____
_____
_____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers

Name	Relationship to patient	Address	Phone	Fax
Name	Relationship to patient	Address	Phone	Fax

I authorize the Department to disclose healthcare information to names above. Valid for one year.

Signature of □Patient □Parent/Guardian _____ Date: _____
Printed name of Parent/Guardian: _____

Reviewed by SBUH SLP_____ _____
Name/ ID number **date/time**

SLP Notes: